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LAWYERS, like other professionals, must for the most part deal with problems of drug dependence[1] as they involve individuals and not as abstractions. For the purpose of dealing with such cases a classification of persons is as necessary and useful as is a classification of drugs or offenses. This presentation will be developed around two classes of drug cases, namely the medical type and the street or delinquent type. Data will be presented to show that differences of motive play a key role in separating these two types. The effects of this particular factor are permanent. They influence the clinical syndrome, the associated epidemiology, the course, the outcome and above all the social significance of the condition. It would appear that the body of data to be described and perhaps the way of looking at drug-dependent persons will be of legal interest on at least three grounds:

(1) The medical type of case is rarely seen in the courtroom and its characteristics may not be well-known outside of medical practice.

(2) The law and lawyers today play an increasingly important role in bringing drug cases to rehabilitation and treatment. Since the condition is no longer regarded only as a moral problem or one of crime, guilt or innocence is no longer the sole issue and simple punishment is not an accepted solution. Being recognized as an illness, drug dependence calls for the more complex process of treatment and rehabilitation. Thus lawyers as well as others who deal with these cases will need to be more fully informed about the needs and characteristics of these persons. This is particularly true of the varied clinical pictures which are now emerging in connection with new drugs of dependence, some of which will be discussed later.

(3) Perhaps most important of all is the need of the legal profession to be informed about such aspects of drug dependence in order to discharge its function in shaping public

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[1] "Drug dependence" is a term which includes drug addiction and drug abuse.

> opinion about drug-dependent persons and in framing legislation to carry out public policy. There is good reason to believe that in the past the heat of controversy and the need to simplify complex questions for public discussion has led to forgetting the differences among various types of addicts or abusers, especially the medical and the delinquent varieties. One of the most spectacular examples occurred during the controversy about the so-called "British narcotic system" which will be discussed below.

Before going on, however, I would like to say explicitly that I have not intended to do more than describe a body of data and a beginning of a classification which is not based on the drugs used. This is offered in a legal context as background information only. I do not purport to comment on the content of laws and regulations; indeed, I do not know if it would be either possible or desirable to establish a statutory distinction between classes of cases such as the medical and the delinquent types. I am not aware of any instance in which injustice has resulted, probably because the administrative structure of drug rehabilitation is quite sensitive to such differences as they involve individual cases. However, it is in the broader context of general discussion that the distinctions are lost to sight and another type of injustice does occur—an injustice in public attitudes. In any event, the purely legal issues are not relevant to the theme of this paper, which is to describe and to differentiate and to offer an interpretation of the data. The emphasis will be on two groups—the medical and the delinquent types—but others are also touched upon, and the conclusion will be drawn that to mingle all classes of drug-dependent persons into one conglomerate of thought can produce only confusion, contradiction and a trend toward false simplications with Procrustean solutions.

A Classification of Drug Dependent Persons

The two categories of classification selected for this discussion are not based primarily on the pharmacology of the drugs employed but rather on the way in which the drugs are used. The author will maintain that, depending on purpose and motive, different drugs may produce very similar patterns of drug addiction or abuse, while conversely a given drug may become the cause of different kinds of drug dependence. This approach allows for a classification of persons rather than of the drugs which they abuse or to which they are addicted, and is based ultimately on a classification of purpose and intent. On this axis of classification other classes of drug-dependent persons may be identified. Among them are individuals who take drugs for religious reasons. It is further recognized that not all

nonmedical addicts or abusers are necessarily delinquent types, but attention will be directed toward two extreme varieties because they illustrate certain principles quite clearly and have been very carefully studied. It is hoped that this classification will be of particular interest from the legal point of view, since the distinction between these two classes of persons is much less obvious during general and public discussions than during disposition of individual cases. In the heat of debate the only distinctions which emerge clearly are those based on the drugs and their pharmacology, and even here there is considerable confusion. The tendency to make sweeping judgments about each drug is strongly reinforced by the legal sanctions based on misuse of specific drugs or groups of drugs. During periods of public concern about drug problems, proposals for action tend to be global and to cover all types of abusers of specific drugs or groups of drugs such as opiates, hallucinogens, sedatives and stimulants. The result has been that the law and its enforcement have been subject to conflicting, rapidly shifting and contradictory demands depending on what type of drug abuser is at the focus of attention. Liberal attitudes are obviously reinforced by emphasis on the medical type of case, and restrictive proposals relate clearly to street or delinquent types.

The Erroneous Addict-Abuser Dichotomy

In one sense this article may be seen as an application of basic rules of classification to persons with drug problems, and of the generally accepted principle that no one method or axis of classification covers all needs—the data in any field of human experience requiring classification in different ways if it is to be appropriate for different purposes.[2]

In the past there has been a tendency to rely too exclusively on purely pharmacological data for all sorts of classification in this field. This includes reliance on the terms "drug addict" or "drug abuser," which are nothing more than a paraphrase of a single pharmacological characteristic of the drugs capable of producing dependence. "Addict" means that the individual is physically and psychologically dependent and is taking excessive amounts of a drug from which he will have physical and psychological symptoms on withdrawal. The term "drug abuser" means only that the person is psychologically dependent, and that the drug he uses will produce psychological but no gross physical disorders when it is withdrawn. Both the "addict" and the "abuser," of course, take the drug or drugs for the effect on their psychic life.

[2] K. JASPERS, GENERAL PSYCHOPATHOLOGY 43 (1963).

A vast amount of illogical reasoning is based on this simple and misleading dichotomy between "abuser" and "addict." It will be one of the main purposes of this article to show that a far more complex formulation of drug dependence must be used in the classification of persons, and that one must take into consideration the differences in individuals, their motive and intent, and environmental influences. Today, when narcotic addicts are already moving through legal channels toward treatment and when other forms of drug dependence may soon be involved in some similar way,[3] it would appear that from the legal point of view it is important to make use of the most complete, available method of classifying drug-dependent persons. The basic characteristics which will be discussed are generally well-recognized in the medical literature, but the arrangements, tabulations and interpretations are based in large part on the author's personal experience and contact with others who have worked in this field.

The British Narcotic Controversy

Some will feel that this analysis is unnecessary because the term "medical addict" is so well-known. Its full significance, however, does not appear to have been generally appreciated, and in the past it has often been lost to sight completely. This happened during the long controversy over the merits of the British narcotic system, and led to confusion and reactions of a type which suggests that we may generalize from this example: Much of the disagreement and misunderstanding which has existed around the question of "medical" as opposed to "punitive" treatment for addicts involves a failure to recognize the fact that conclusions based on one class are not necessarily valid for the other.

This controversy originated in the mid-1950's with the appearance of popular accounts of a "system" in Britain under which it was claimed that registered addicts received regular supplies of narcotics in clinics, legally forestalling any black market operations and accounting for a wide range of benefits—including the presence of only a few hundred addicts in all of Britain. Careful investigation by a number of authors, including Dr. Larimore and this writer,[4] clearly showed that there was no registration and no clinic system,

[3] There is already some discussion of compulsory treatment for at least some types of drug dependency similar to that already provided for opiate cases. *See* N.Y. MENTAL HYGIENE LAW §§ 200-17 (McKinney Supp. 1967); Narcotic Addict Rehabilitation Act of 1966, 80 Stat. 1438 (codified in scattered sections of 18, 28 U.S.C.).
in scattered sections of 18, 28 U.S.C.).

[4] Laremore & Brill, *The British Narcotic System, Report of a Study*, 60.1 N.Y. ST. J. MED. 107-15 (1960).

and that the British had no "street" problem but only medical addicts. Since then delinquent addiction has sprung up and is now forcing the British government to restrict the physician's right to prescribe.[5] Until the appearance of the new class of addict, physicians had been allowed to provide for their addicted cases, and so long as they were of the medical type this caused no problem. When they tried to do this with "street" addicts a rapid escalation of heroin addiction promptly followed.[6]

Drug Dependence Defined

We will avoid the use of the terms "drug addiction" and "drug abuse" as well as the related terms "addict," "misuse" and "habit-forming." Completely misleading connotations have attached to these words. It has, for example, been widely assumed that they represent a direct measure of the seriousness of the hazard of the drugs concerned. That this is completely false is revealed by the fact that in this type of classification cocaine is not "addicting" but only "habit-forming" since it produces no physical dependence; and yet cocaine is generally recognized as capable of producing one of the most pernicious types of drug dependence—intractable to treatment, punctuated by psychotic attacks and marked by severe social and economic disability. Therefore, instead of terms such as "addiction" and "habit-forming," we shall follow the classification of drugs prepared by the World Health Organization Expert Committee on Addiction-Producing Drugs.[7] In this system the term "drug dependence" is the major heading which includes all types of compulsive, harmful drug-taking, and the specific sub-type is defined by the kind of drug involved. This system gives us such terms as "drug dependence of the opiate type," the "barbiturate-alcohol type," or the "amphetamine type." The terminology allows for a more precise communication, but it is only a classification of pharmacological actions; it does not satisfy the need for classifications of other types of data, including a classification of persons who take drugs. It is in this area that the major interest of this article will lie.

The Medical and the Nonmedical Forms of Drug Dependence

The distinction between medical and nonmedical drug dependence is based primarily on the way in which the condition arose.

[5] *New Measures to Control Addiction*, THE LANCET, Feb. 4, 1967, at 282; The Times (London), Jan. 31, 1967, at 1, col. 1; DRUG ADDICTION—THE SECOND REPORT OF THE INTERDEPARTMENTAL COMMITTEE (1965) (SECOND BRAIN REPORT).

[6] Bewley, *Heroine Addiction in the United Kingdom (1954-64)*, 2 BRITISH MED. J. 1284-86 (1965); *Failure of Permissiveness*, TIME, Feb. 17, 1967, at 76.

[7] Eddy, Halbach, Isbill & Seevers, *Drug Dependence: Its Significance and Characteristics*, 32 WORLD HEALTH ORG. BULL. 721, 722 (1965).

If it began in the course of treatment for an illness, disorder, or symptom it is classified as "medical." It is "nonmedical" if the drug was taken originally for other purposes, and this practically always denotes a hedonistic, pleasure-seeking purpose.

The nature of the original intent might at first sight appear to be an accidental circumstance of little importance, especially after the habit has become well-established and self-perpetuating through the induced compulsive drive for drugs. Furthermore, from the legal point of view the infractions which are involved may be identical. Yet this is an erroneous interpretation, and it will be shown that *the original intent provides a fundamental orientation which propagates its influence throughout the entire subsequent course of the case.* It constitutes a distinguishing mark to identify a class of cases which differs sharply from the delinquent and street type. This is confirmed by experience; and as a matter of logic one can assume that the original needs of an individual play a role in each successive experience, and in a sense are thus recycled and may even be reinforced with the passage of time.

Flight from discomfort is a basically different reaction from the pursuit of pleasure, in spite of the fact that philosophical questions may be raised about some deeper unity between the two. A second and perhaps decisive reason why the two types of cases do not tend to merge after the passage of time is the fact that the original situation acts as a selection factor. The type of person who is likely to be motivated by pursuit of pleasure and is drawn into the habit by the social use of drugs is quite different from the one who is first driven to drugs for emotional shelter and control of symptoms and then finds that he cannot give up this form of relief from stress. While one may debate the reasons, the fact is that the two groups show striking differences as to the types of persons involved, the kinds of reactions which are manifested and the social hazards which they represent.

The contrast between the medical and nonmedical type of case is well-exemplified in opiate dependence, as seen in the following tabular presentation.

Some Contrasts in Two Types of Opiate Dependence—Table A

The Therapeutic Type of Opiate Addict (Medical Addict)

To explain the table below somewhat more completely, we may say that the person who first becomes involved with opiates in a medical context is likely to be aged 30 or beyond, women appearing to be as vulnerable as men since they are represented in equal num-

Table A

CHARACTERISTIC	NONMEDICAL (STREET ADDICT)	MEDICAL
Usual age range of cases	18 to 30 (average 27).	30 and beyond (average 40).
Male/female ratio	6 or 8 men to each woman.	Female incidence equals that of male.
Locale	Cases tightly clustered in specific metropolitan areas.	Cases dispersed.
Drugs used	Heroin is the drug of choice; multiple drug use is the rule, marijuana frequent.	Morphine and demerol the prevailing drugs; heroin rare in U.S., infrequent abroad.
Psychiatric classification	Character and personality disorders.	Neuroses, depressions, and psychoses; psychosomatic disorders.
Psychiatric history	Conduct disorder only.	Long history of subjective symptoms, often psychosomatic.
Severity of habit	Fluctuating but characteristically severe.	Varies in severity; unknown proportion of cases thought to follow stable dosage.
Degree of economic disability	Severe as a rule often to the point of vagabondage (periodic).	Serious but often not complete; many retain a degree of marginal productivity.
Effect of maturation	A proportion of cases recover as they age (loss of capacity for euphoric reaction?).	Probably not a factor.
Condition after drug withdrawal is completed	Marked physical and mental improvement is the rule.	An underlying psychiatric disturbance may be uncovered or existing one increase in severity.
Delinquency	Frequent before, and during addiction; also seen after.	Delinquency not a feature prior to addiction; tends to be limited to technical infractions during addiction.
Way in which habit began	Usually "on the street" under social pressure of a group and seeking pleasure.	Under medical conditions. For treatment of a complaint.
Social use of drugs	Frequent use in groups.	Solitary use only.
Psychic contagion	Primary mode of spread. May assume epidemic proportions.	Not a problem.
Attitude toward drug use	Often seen as highly desirable.	Guilt and anxiety.

bers.[8] These persons begin their drug-taking individually—not in group activity—and continue it in solitude as a secret, guilt-laden practice which is a source of continual anxiety. They are not found clustered in any given location but are distributed in a sporadic way in all areas and among all classes of society. There is perhaps a greater incidence among the types of persons who have a considerable amount of leisure than among others. While these persons use opiates, they are not involved with heroin but prefer chiefly mepridine (demerol) or morphine with a sprinkling of other opiates, all of them of legal type. Multiple drug use is not the rule. The medical type of case often struggles on for decades, maintaining himself at a marginal economic level, carrying the combined burden of the primary disorder along with the acquired one of drug dependence. Such persons may long retain a respectable place in society but their course is often very fluctuating. They characteristically have no antisocial record except that related to the purchase or possession of drugs for their own use, many of them belonging to the professional classes.[9] It has, incidentally, been pointed out many times that doctors and nurses are disproportionally represented.[10] This fact might seem to throw some doubt on the value of antinarcotic education, since even full professional knowledge of the hazards of opiates has not protected such persons. It is, however, possible that this merely proves that too much familiarity with actual use of drugs breeds indifference to their addicting power. Pharmacists do not tend to abuse medications although they also handle narcotics, and the difference may be that pharmacists do not have so much opportunity actually to administer these drugs, to observe their action directly, and to see how harmless they appear to be for most persons.

It is when we come to the psychiatry of the opiate case that we find occasional overlap between the therapeutic and street addict types. In spite of all that has been said about their professional status, not a few of the medical cases are of unstable temperament and often have amoral tendencies. They are given to shallow friendships and attachments; many of them appear incapable of forming deep bonds of affection, and are not highly trustworthy. Yet on the other hand many suffer severe anxiety and other neurotic illness, and instances of full-blown depressions and schizophrenia are not rare.

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[8] *See* Bewley, *supra* note 6, at 1285.

[9] Winick, *Physician Narcotic Addicts*, 9 SOC. PROB. 174-86 (1961).

[10] Ehrhardt, *Drug Addiction in the Medical and Allied Professions in Germany*, 11 BULL. ON NARCOTICS 18, 19 (1959).

The Nonmedical Delinquent Type

The second type of case, namely the street or delinquent addict, is usually a young male. In the United States he is often from a minority group, but this is not the case in Japan or England.[11] He is quite likely to come from one of the notorious endemic narcotic areas of a large city which maintains an open market for the drug. His motive in first taking drugs is variously described as seeking peer acceptance or imitating his elders, but a most important inducement—whether verbalized by others or felt in himself—is the expectation of a euphoric reaction, pleasurable beyond the normal reach of human experience including that of sexual orgasm. A marked preference for heroin is an outstanding feature of this type of case, but multiple drug use is very frequent in the form of simultaneous or successive combinations; and when heroin is not available the most bizarre and dangerous varieties of inebriating substances are used in its place. Such cases are found to have backgrounds of varied delinquencies which frequently began before the drug use commenced, and they may have experimented with a variety of drugs before coming to heroin. Careful examination may and often does elicit neurotic, depressive or schizoid traits, but the essential picture is that of personality disorder marked by shallow facile emotions, unreliability, intolerance of discomfort or frustration and inability to delay satisfaction of drives. Bonds of affection are weak, and there is remarkably little tendency to benefit by experiences which might be corrective of the delinquent style of life. During periods of active drug use hygiene is usually abominable, and the addict's needle techniques are so bad that he is exposed to every type of intravenous damage. When he is "clean," that is, free of drugs, he tends to be quite fastidious, and when such cases report for aftercare many of them are seen to be very "sharp" dressers. Pride in physical appearance is very great, and in hospital it is reflected in tendencies to walk about wards stripped to the waist and to indulge in muscle-building exercises. Food is extremely important to them and their demands are heavy and exacting. The inclination to manipulate the environment for short-term goals is a constant problem, and instability of purpose is strongly marked. When such a person volunteers to enter a hospital program, he demands immediate admission and gives all sorts of plausible arguments why he cannot wait for even a day. Once admitted, he usually reverses his intentions and becomes equally urgent about his immediate release on the next day.

[11] Council on Mental Health, *Narcotics and Medical Practice*, 185:2 J.A.M.A. 976, 977 (Sept. 21, 1963); Pharmaceutical and Supply Bureau, Ministry of Health and Welfare, *Statistics on Narcotic Offenses and Narcotic Addicts* (1963): of 2,571 arrested cases 2,352 were Japanese, 186 Korean, 25 Chinese and 8 others.

In either case he can be equally plausible and will emphasize every aspect of the situation except the crucial one: his inability to follow any one course of action for very long unless it leads to drugs. Lack of program, boredom, defects in food, unsympathetic attitudes of personnel or professional staff, institutional restrictions, isolated location of the facility, and the profound conviction that he has recovered completely and has finally "learned his lesson" are all equally useful grounds to justify abrupt termination of treatment. Flight from treatment—"splitting"—is a prominent part of the addict subculture. It is of considerable interest with respect to their instability of purpose, however, that some 25 percent of those who "split" from New York State treatment facilities return voluntarily within a period of days, and another 25 percent are brought back under circumstances which can only be described as semi-voluntary.

In general, the nonmedical case is far more disabled socially and economically than the therapeutic one, and is often reduced to the level of vagabondage for periods of time. The pursuit of the drug experience becomes his main interest in life and he shows a strong tendency to escalation of dosage, multiple forms of drug dependence, and antisocial conduct aside from direct drug infractions.

Drug Dependence of the Barbiturate-Sedative Type and the Amphetamine Type

What has been said about the opiates applies in its essentials to other substances which are capable of producing significant and harmful dependence, although there are major differences which turn on specifics of pharmacological action and on certain secondary conditions surrounding the drug use. The two most important classes of such drugs and the most instructive for our presentation are the amphetamines and the barbiturate-sedative group. The pharmacological action of the two is fundamentally different, the first being stimulant and the second sedative; yet the nonmedical or street type of amphetamine abuser has little in common with a medical or therapeutic case who is dependent on the same drug, but he does have a great deal in common with the nonmedical barbiturate addict. A parallel statement applies to barbiturate dependent persons. Many cases use both types of drugs. Thus, for purposes of classifying persons the pharmacological actions of the drugs taken are less significant than are the motives and purposes behind the drug use. This may be seen in the tabulation of characteristics of the two types of cases which appear below. For many practical purposes, including medico-legal ones, such a classification is more appropriate than one which is based on pharmacological action.

Contrasting Characteristics of Two Types of Dependence on Amphetamines and/or Barbiturate-Sedative Drugs—Table B

The Medical (Therapeutic) Type of Amphetamine and/or Barbiturate Dependence

From the schema below it may be seen that for social and perhaps for legal purposes there are two types of barbiturate dependent persons who have almost nothing in common except the use of the same drug. They are essentially similar to the two kinds of amphetamine cases, and in fact many persons combine the drugs. Thus it is clear that different types of drugs can produce the same social results and create similar legal problems if they are used with the same type of intent. Such a hazard exists in common among all drugs which are capable of inducing a compulsive need and which can provide a significant intensity of intoxication as measured by the degree of interference with psychic functioning. The presence or absence of physical dependence as shown by physical symptoms on withdrawal appears to be an accessory and not a basic characteristic. If these requirements are fulfilled other details of the pharmacological actions to which persons subject themselves seem less important socially than the *purpose* with which this is done. The distinction between therapeutic cases and street addicts is even more important here than it is in the case of the opiates because the majority of persons dependent on barbiturates and a very large number of amphetamine cases belong to the medical or therapeutic class. This is in sharp contrast to the opiates, where they are a small minority. The therapeutic type of barbiturate or amphetamine case suffers from the widest variety of psychiatric mental and emotional problems and disorders. Their drugs are often secured through nonlegal channels but they are sick persons who are making a bad situation worse by misguided attempts at self-medication. Many of them became physically dependent without being fully aware of the specific dangers involved. This writer has seen persons with this form of barbiturate dependence who thought they had developed epilepsy because of seizures from irregularity of dosage.

These therapeutic addicts carry on their habit alone with a sense of guilt and anxiety; and the amount of drug taken tends to fluctuate with the state of the underlying psychiatric problem. Suicide or semiaccidental death is not an infrequent form of termination. Severe degrees of the medical type of amphetamine dependence are less frequent; and when such cases are encountered a very severe psychopathology is the rule. On the other hand, significant excessive use which grows out of the use of such drugs for reducing or combatting insomnia is frequently encountered in medical practice.

Table B

CHARACTERISTIC	STREET OR DELINQUENT TYPE	MEDICAL OR THERAPEUTIC TYPE
Onset of habit and subsequent basic intent	Social. Begins in imitation of others. Seeking inebriation.	Purpose is medical, often for control of insomnia, tension, anxiety or for weight reduction.
Age range (typical)	12 - 25.	Over 30.
Male/female ratio	6 or 8 males to each female.	Probably equal or females may predominate.
Locale	Suburbs and cities (concentrated in).	Diffuse.
Number of drugs used	Wide variety—different classes of drugs frequent (sedatives, stimulants and hallucinogens).	Usually 1 or 2, not characteristically multiple types.
Psychiatric classification	Personality, character or conduct disorder.	Neurosis, depression or psychosis.
Severity of habit	Variable and often severe. Intravenous route frequent.	All gradations of cases from severe to mild excess. Intravenous route unusual.
Degree of economic incapacity	Severe often to point of vagabondage or complete support by family.	May be serious but usually not complete and characteristically only partial.
Status after completion of withdrawal	Clearcut mental and physical improvement.	Improvement but often complicated by increase of underlying symptoms.
History of delinquent behavior	Marked.	Not a feature.
Social use	The rule is social use to point of inebriation.	Use is solitary.
Attitude about drug use	Defiance.	Guilt and anxiety.
Other characteristic details	Progress to other drugs not unusual.	Suicide a common danger.

Drug dependence of the therapeutic type is a completely graded condition as to severity, and the doses taken range from normal therapeutic levels to fantastically large amounts. In sedatives or stimulants the cases seen cover the full range from almost continuous, heavy intoxication to chronic overuse under some medical guidance. Usually the latter results after the physician has made various frustrated attempts at withdrawal and finally is forced to be content with the level where the patient maintains some degree of social adjustment while he continues on a fixed although excessive dose of drug. In the case of the barbiturate this must be under the level which produces physical dependence, although there usually are periods when control is lost under the stress of intercurrent events or spontaneous fluctuation of the underlying condition.

The nature and extent of concern about this class of problems has been brought home forcefully to this writer when addressing various citizen groups. At such times it is far from unusual to be asked questions about one of the sedatives or minor tranquilizers. It is obvious that in the background is the fear that even from steady, normal, therapeutic, nonescalating doses supervised by a physician there is a significant hazard of "addiction" with all of the dreaded personality changes, physical and mental damage, and social destruction. Such a sense of caution has undoubtedly served the very important purpose of protecting people against an escalation of dose or even an undue prolongation of medication. Nevertheless, such questions are also asked by members of the health professions—even by physicians themselves—indicating a serious confusion about the psychiatry and pharmacology involved. It bespeaks a serious unclearness of thinking on this entire subject, one which can result in either excessive stringency or total relaxation of controls, depending on which type of dependence has been brought to public attention by the flow of events. If it is the medical type of case, the reaction is likely to be lenient, because very large numbers of persons, some of them in quite influential positions, can identify with such individuals. On the other hand, if the delinquent and street type of case is at the focus of public attention the results can be spectacularly different.

Nonmedical Amphetamines and/or Barbiturate Dependence

The typical nonmedical case is a young male delinquent or semidelinquent. He is a member of a social group of similarly minded persons, which often includes a small admixture of girls of the same age and personality structure. The drugs are usually taken in various simultaneous or successive mixtures with each other and with the hallucinogens or alcohol. On occasion, opiates or cocaine are "tried,"

but regular use of hard drugs is not a feature of this class of persons, even though the converse is not true and heroin addicts frequently use all types of "soft drugs." Amphetamines are taken intravenously on occasion, barbiturates somewhat less frequently. Aggressive behavior is not uncommon, and the entire pattern of life tends to be abandoned, nonproductive, irresponsible, hedonistic, aimless and without any apparent long-term goals. These are high school and college drop-outs, unemployed for the most part, and parasitic either on relatives, on their families or on society at large through larceny or prostitution. The prevailing psychiatric status is that of character disorder. These young persons are found widely scattered throughout society, but they are particularly drawing attention today as a growing problem in suburbia. Their habits are contagious because of the group pressures which bring their associates to conform, and for this reason consorting with such persons is a hazardous activity for adolescents. Recruitment goes on continuously by the usual social process and not by any purposeful plan. Mutual selection of congenial companions leads with uncanny accuracy to a gathering of associates vulnerable to drug dependence.

It is hard to see how laws and regulations or procedures which fully meet the needs of such individuals can also fit the needs of the medical type of case. It is far beyond the competence of this writer to suggest how both may be served or indeed if it can be done at all. But if we can judge by the course of events in the opiate field, it is not likely that we shall see a trend toward establishment of a pattern of strict regulations and severe penalties. Nevertheless, plans involving flexible use of compulsion combined with treatment and rehabilitation, now being developed in the opiate field, may eventually have relevance to the other drugs.

Drugs Associated with Only One Type of Dependence

If we extend our inquiry to include other drugs we soon come upon some which do not seem to support two kinds of dependence. The bromides, for example, were once a very serious problem in the United States, and the intoxications which they produced were a significant factor in mental hospital admissions all over the country.[12] Many persons took huge doses in a compulsive fashion and suffered from serious physical and mental complications. Vast amounts of bromides were sold and there was much abuse; exposure of the general population must have been very extensive. Yet bromide dependence was never recognized as a social problem, and there appears to be no evidence that bromide ever was used for social or

[12] *See* STERN, *Psychosis Due to Bromide Intoxication*, 66:4 N.Y. ST. J. MED. 2818-23 (1966).

hedonistic purposes—presumably because it was inherently incapable of such application. Another example of true drug dependence of this type is that of the phenacetin-caffeine mixtures which have been a problem in certain European countries.[13] This is a purely medical problem and has never aroused concern on any other ground. The subjective effects appear to be minimal, yet the drug-taking is clearly compulsive and involves very large doses which finally lead to serious kidney damage. Other, less well-known examples can also be cited. Compulsive salt-taking has recently been reported, as well as cortisone addiction and the compulsive taking of soda bicarbonate.[14] Taken together these instances seem to offer strong evidence that drugs may be able to induce classical states of dependence with compulsive taking of very large doses, and yet be quite free of the capacity to support a habit of the delinquent or hedonistic type which has created so much anxiety currently.

The opposite extreme is less easily demonstrated in such pure form, but it appears that a large number of the current users of LSD and the related hallucinogens belong to the nontherapeutic, hedonistic and delinquent class. Experience with this type of drug is as yet relatively short, however, and it has been largely confined to a relatively atypical population. Yet the information which is available appears to support the basic conclusion about type of use. Similar statements might be made about the other hallucinogens.[15] For all practical purposes, cocaine also exists in this country purely as a drug of the street addict, but it is capable of creating a medical type of dependence. The story of its original introduction into medicine is one of the most sensational chapters in the annals of medical types of addiction, having involved Sigmund Freud himself as well as many less well-known physicians.[16]

For the sake of completeness we may point out that there are many possible permutations of intensity of drug action, their capacity to induce dependence, and the purposes with which they are used. Some drugs are limited as to dependency hazard by the weakness of their pharmacological action, yet have a social use through producing mild pleasurable reactions without any visible distortion of reality. Among them we may list such well-known items as tea, coffee and tobacco. We may also keep in mind that social results of drug-taking are significantly modified by a bona fide religious intent (as is the case with the use of peyote in certain Indian tribes).[17] All of

[13] *See* Smith, *Pathogenesis of the Renal Lesion Associated with the Abuse of Analgesics*, THE LANCET, Apr. 22, 1967, at 859-62.

[14] *Compulsive Salt Intake and Oedema*, THE LANCET, July 29, 1967, at 261.

[15] DET, DMT, "STP," hashish, etc.

[16] S. FREUD, THE COCAINE PAPERS (1963).

[17] *See* People v. Woody, 61 Cal. 2d 716, 394 P.2d 813, 40 Cal. Rptr. 68 (1964).

these have an interest of their own, but do not appear to bear directly on the questions we are discussing. An attempt to explore them would take us very far afield, yet they must be mentioned to acknowledge the fact that they can be used as examples by those who will find reason to object to the main conclusions of this analysis. Other types of objections may also be anticipated.

Possible Objections to Intent as a Central Issue in Classification of Drug Dependent Persons

A most serious question may be raised as to the value of specifically identifying the factor of intent or motive as crucial in the final outcome of drug-taking. It may be said that this is merely an indirect way of describing the psychiatric diagnosis, adding nothing and conveying a much smaller amount of information than could be had from the diagnosis itself. It is true that in general the person with a character disorder will be found in the delinquent class of drug abusers, while most cases of neurosis, depression and some psychotics will be found in the medical group. Nevertheless, the objection is not completely valid. Diagnosis is only partly synonymous with type of drug use, and many exceptions are found in the distribution of psychiatric types between our two classes of drug dependence. On this point it is most convincing that the opiates, including morphine, were once used in heavy doses for the treatment of mental disorder—and a very large literature exists to show that addiction of any type was not a complication that caused concern in this procedure.[18] Something more is required than the existence of mental or emotional problems. Serious and permanent dependence develops only if there is specific vulnerability, and then the type appears to be controlled by the mental attitude and the intent of the user. Purely physical dependence on opiates, if not complicated by psychic predisposition, is easily reversed.[19] A similar statement may be made about experience with opiates in surgery.[20] Almost as convincing is the fact that when phenobarbital was the main treatment of epilepsy, addiction was not a problem with epileptics, and compulsive drug-taking with escalation of doses did not occur even though a considerable number of cases were given doses high enough to create physical dependence.[21] Although phenobarbital is not a

[18] 2 D. TUKE & J. CHURCHILL, A DICTIONARY OF PSYCHOLOGICAL MEDICINE 1140-43 (1892).

[19] Such situations occur not infrequently in the course of surgical treatment. Persons with painful conditions may receive enough opiates to show significant symptoms of withdrawal. But this is easily carried out in normal persons. Addiction here is rare and considered evidence of predisposition. *See also* Council on Mental Health, *supra* note 11, at 977.

[20] Council on Mental Health, *supra* note 11, at 977.

[21] Personal experience of the author as Director of Craig Colony, a 2,000 bed hospital for epilepsy.

drug of choice among drug abusers, it has nevertheless been shown to be capable of maintaining a habit. Recent experience with the hallucinogens further emphasizes the importance of mental set and intent in the nature of the initial drug experience and in the subsequent reactions as they are built up in a series of drug experiences. Another fact which argues strongly in favor of intent as an independent variable in the genesis of drug dependence is that many substances had long medical use before their potential for creating dependence became known—some of the most striking ones being opium, morphine, heroin, amphetamines and the barbiturates. Once this characteristic became generally known, spread of dependence was very rapid and took the classical pattern of the spread "in the street." It would seem that some cases of dependence of the medical type must have occurred previously, but that until the inebriation value was known and the drug could be taken with this intent no spread of the street habit could occur. Once the news was out, however, this period of apparent immunity was terminated. Aside from this explanation the historical lag between introduction of drug and the outbreak of dependence problems appears to be quite inexplicable.

We may anticipate another objection: that this presentation has oversimplified the situation and reduced it to the operation of a single factor. This has not been the author's purpose, and it should be emphasized that the factors of motive and intent are recognized to be only a part of a much broader set of influences. Drug dependence is a resultant of at least three main groups of factors, and in describing any one it is easy to forget that each provides a necessary condition but that the sufficient cause is their joint presence, a situation analogous to that of infection. The agent must be a drug capable of producing dependence. If a social problem is to result it must be capable of producing a powerful effect on the mind. Such a drug can produce dependence only in a suitably vulnerable individual, but the vulnerability appears to be a relative matter, strongly conditioned on the third set of factors, namely, the environmental situation. It is here that the influences operate which produce mental set and create the intent and motive about which we have been talking.

It may be objected by some that the entire effort of this analysis is superfluous and that the distinctions between the medical and nonmedical type of case are well-recognized and established beyond the need of further examination. That they are recognized is an unquestioned fact, but it is by no means clear that the distinction has been given the emphasis that it merits or that it is not frequently forgotten altogether. In too many contexts all types of drug cases are reduced to a single category and the discussion is carried out in terms of "the addict," indicating that this is a single problem which

has a single solution, and that observations on one class of case are valid for all others. No more flagrant example is to be found than in the long drawn-out public controversy about the British narcotic system.[22] We are not here concerned with the merits of the case but only with the fact that in the entire nationwide discussion there was virtually no recognition of the fact that the British problem consisted of a group of typical medical addicts, while the American problem was made up essentially of equally typical street addicts. This single fact of classification made the British experience generally inapplicable to the American problem. In this case the decisive classification was not that of the drug, but of the persons involved, and more specifically of their motives and intent with respect to drug use.

It is most encouraging that current developments are moving in the direction of compromise; we should seek practical solutions which are as satisfactory as possible from all points of view. Treatment programs such as that provided in the 1966 federal law (The Narcotic Rehabilitation Act of 1966)[23] and in the laws of states like California[24] and New York[25] are a long step toward such a solution. The comprehensive New York State program is a full-scale approach to the problem posed by its 30,000 narcotic cases. It seeks to base the process of treatment and rehabilitation on the specific needs of various types of opiate-dependent persons and, with certain numerically unimportant exceptions, action is not predicated on the nature of the incident which brought the addict before the court. At the same time, authority is retained to apply the necessary degree of compulsion to assure that the addict will not fall victim to his own traditional instability of purpose and evade the treatment process.

Inherent in all of the current changes in legislation as well as judicial decisions is the need for a more effective matching of persons to the very considerable variety of treatment modalities which are now available. This will require a more effective and valid set of methods of classification of persons and their needs, and a more consistent application of such classifications. It can be expected that this will have the additional value of permitting a more orderly and meaningful arrangement of data in the field. It may also help clarify old concepts and remove such points of friction and misunderstanding as have been based on our attempts to deal with a series of problems as if they were all one.[26]

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[22] *See* text accompanying notes 4-6 *supra.*

[23] Narcotic Addict Rehabilitation Act of 1966, 80 Stat. 1438 (codified in scattered sections of 18, 28 U.S.C.).

[24] CAL. WELF. & INST'NS CODE §§ 6350-62.

[25] N.Y. MENTAL HYGIENE LAW §§ 200-17 (McKinney Supp. 1967).

[26] Brill, *Misapprehensions about Drug Addiction. Some Origins and Repercussions,* 4 COMPREHENSIVE PSYCHIATRY 150 (1963).

Conclusion

It has been the purpose of this article to describe the differences between medical or therapeutic drug dependent persons on the one hand and the delinquent or street type on the other. The importance of the distinction has been stressed and some explanations proposed as to their genesis. In particular the intent and motive with which the drugs are taken has been assigned a central role. Finally an effort has been made to anticipate some of the objections which may be raised against these interpretations.

In this field, contradictory and confusing attitudes and conflicting demands on the law and its enforcement have long been a problem; they may be traced in significant degree to a tendency to forget the differences between therapeutic and street addicts. This oversimplification tends to reduce all forms of drug dependence to a single category and then to propose policies which are applicable to all of them. An outstanding result is the tendency of some authorities to view the basic issue as that of delinquency, while the others see the difficulty as an illness or a disorder perhaps on the level of an irresistible impulse artificially produced by drugs. The situation is further complicated by a tendency in the public to see the problem first in one way then in the other. The need to reconcile these divergent views has long been evident, and the way now appears to have been opened by legislation and by judicial decisions supporting the use of legal compulsion where needed and to the degree that is necessary, but requiring its employment for administration of treatment and rehabilitation. Implicit in all this is the requirement that treatment and rehabilitation shall be suited to the needs of the individual case. This calls for the most accurate classification possible and the clearest delineation of differences among cases. It is hoped that the proposals in this article will contribute toward a very much needed improvement in classification.